Initial Approval: October 12, 2016

CRITERIA FOR PRIOR AUTHORIZATION

Intranasal Antihistamine/Corticosteroid Agents Step Therapy

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Azelastine/fluticasone (Dymista®)

CRITERIA FOR PRIOR AUTHORIZATION APPROVAL (must meet all of the following):

- Patient must have a diagnosis of seasonal allergic rhinitis
- Patient must have a trial of concurrent use of a nasal antihistamine plus intranasal corticosteroid for at least 90 days

LENGTH OF APPROVAL: 12 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR	PHARMACY PROGRAM MANAGER DIVISION OF HEALTH CARE FINANCE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
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DATE	DATE